ARIZONA DEPARTMENT OF VETERANS' SERVICES
WORKER'S REPORT OF INJURY

(MUST BE FILLED OUT COMPLETELY AND SIGNED BY A SUPERVISOR)

EMPLOYEE NAME:	**SOCIAL SECURITY NUMBER:**	**DATE OF BIRTH:**
EMPLOYEE'S ADDRESS:	**CITY:**	**STATE:** **ZIP:**
MARITAL STATUS: **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐		**SEX :** **FEMALE** ☐ **MALE** ☐
HOME TELEPHONE:	**MESSAGE PHONE:**	
DATE OF INJURY: / /	**TIME:** **A.M.** ☐ **P.M.** ☐	**DATE EMPLOYER NOTIFIED:** / /
DID YOU LOSE MORE THAN ONE DAY OF WORK? **YES** ☐ **NO** ☐ *ALL TIME LOST (MORE THAN ONE DAY) MUST BE REPORTED TO H.R. WITHIN 3 DAYS.		**LAST DAY WORKED:** / /
OCCUPATION:		**DATE OF HIRE:** / /
ACCIDENT LOCATION:	**CITY:**	**STATE:** **ZIP:**
SEEN BY A HEALTH CARE PRACTIONER **YES** ☐ **NO** ☐	**NAME:**	**PHONE:**
ADDRESS:	**CITY:**	**STATE:** **ZIP:**
HOSPITALIZED: **YES** ☐ **NO** ☐	**NAME/ADDRESS:**	**CITY:** **STATE:** **ZIP:**
PART OF BODY INJURED:_____ **RIGHT** ☐ **LEFT** ☐ **TOP** ☐ **BOTTOM** ☐ **SIDE** ☐	**FATAL:** **YES** ☐ **NO** ☐	**TYPE OF INJURY: (STRAIN, CUT, BRUISE, BROKEN BONE, BURN, ETC.)**
HOW DID THE ACCIDENT HAPPEN?		
WHAT COULD HAVE BEEN DONE TO PREVENT THE ACCIDENT?		
DO YOU DOUBT THE VALIDITY OF THE THIS CLAIM: YES ☐ NO ☐ (IF YES PLEASE ATTACH A MEMO EXPLAINING WHY?)		
WERE OTHERS INJURED IN THIS ACCIDENT: **YES** ☐ **NO** ☐	**IF YES, WHO?**	
WAS PROTECTIVE EQUIPMENT WORN AT TIME OF ACCIDENT? **YES** ☐ **NO** ☐	**IF YES, SPECIFY?**	
LIST WITNESSES TO MISHAP/ACCIDENT:		
INJURED EMPLOYEE'S SUPERVISOR NAME:	**TITLE:**	**PHONE:**
INJURED EMPLOYEES SIGNATURE:		**DATE:**
WAS 542 -WORK (542-9675) CALLED WITHIN 24 HOURS OF ACCIDENT IF SEEKING MEDICAL TREATMENT? YES ☐ NO ☐		**DATE:**
SUPERVISOR'S SIGNATURE:		**DATE:**

Note: The Worker's Report of Injury (AVSC 01-081) must be completed by the employee before the end of the shift in which the injury occurred. The Worker's Report of Injury must be signed by the injured employee's supervisor and filed with Human Resources.

WORKER'S COMPENSATION EARLY CLAIMS NOTIFICATION
24-HOUR HOTLINE
(602) 542-WORK (9675) OR 1-800-837-8583

WITHIN 48 HOURS, THE INJURED EMPLOYEE OR THE SUPERVISOR MUST CALL IN AND ANSWER TO THE FOLLOWING QUESTIONS TO THE EARLY CLAIMS NOTIFICATION HOTLINE:

1. **Please state your name, and the injured employee's agency.**
2. **Please state the name, address, and telephone number of the injured employee.**
3. **What is the injured employee's social security number?**
4. **What is the name and daytime telephone number of the employee's supervisor?**
5. **Please describe how the accident happened?**
6. **What is the date that the employee was injured?**
7. **Describe the injury and part of the body that was injured.**
8. **Please state the name of any witnesses to the injury.**
9. **Is the employee missing time from work?**
10. **If the accident was the fault of someone else, please state that person's name and address.**
11. **Has medical treatment been provided?**
12. **If yes, state the name of any physicians or hospitals that have provided treatment.**

There are times when the Worker's Report of Injury is completed and the injured employee does not intend to seek medical treatment. The injured employee may later go to the doctor if the condition is not resolved.

The injured employee must provide Human Resources within 24-hours of treatment with the Physician's name, address and phone number